MDR Tracking Number: M5-04-1197-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 12-29-03.

The IRO reviewed office visits and physical therapy treatment rendered from 01-17-03 through 8-8-03 that were denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On March 11, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
12-30-02 01-02-03 01-03-03 02-28-03	99212	$35.00	$0.00	F	$32.00	Evaluation & Management GR (VI)	The requestor failed to submit medical records to support fee dispute and challenge insurance carrier's position per Rule 133.307(g)(3)(B). Therefore, reimbursement is not recommended.
12-30-02 01-02-03 01-03-03 2-28-03	97250	$45.00	$0.00	F	$43.00	CPT Code Descriptor	
12-30-02	97150 (7)	$189.00	$0.00	F	$27.00	Medicine GR (I)(A)(9)(b)	
01-02-03	97150 (5)	$135.00	$0.00	F			
01-03-03	97150 (6)	$162.00	$0.00	F			
02-28-03	97110(1)	$35.00	$0.00	F	$35.00 / 15 min		
02-28-03	97010	$15.00	$0.00	F	$11.00	CPT Code Descriptor	

IV. DECISION

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor **is not** entitled to reimbursement for CPT codes, 99212, 97250, 97150, 97110 and 97010.

The above Findings and Decision are hereby issued this 19th day of August 2004.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

March 10, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-1197-01
IRO Certificate #: 5348

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 42 year-old male who sustained a work related injury on ___. The patient reported that while at work he was lifting bags into a dryfeeder when he slipped and fell injuring his back. The patient was evaluated and began treatment with home spinal stretches, ultrasound, myotherapy, therapeutic exercises and kinetic activity involving various exercise apparatus for aerobic and strengthening. The patient underwent an MRI on 3/14/02 of the lumbar spine that showed a transitional S1 segment, Grade I spondylolisthesis of L5 and S1 and degenerative disc disease at L5/S1 with posterior osteophytes, annular bulge and bilateral neuroforaminal stenosis. A neurological evaluation performed on 5/19/02 noted that the

impression for this patient was lumbar mechanical pain and radiculopathy and probable disc protrusion. The patient was recommended for injections and possible surgery. The patient continued with chiropractic treatment through 8/14/02. On 8/16/02 the patient underwent lumbar fusion surgery. The patient was treated postoperatively with physical therapy and rehabilitation beginning 12/9/02.

Requested Services

Hot/cold pack therapy, therapeutic exercises, massage therapy, therapeutic procedures, myofasical release, ultrasound, office visits (99212) and office visits (99212-52) from 1/17/03 through 8/8/03.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a 42 year-old male who sustained a work related injury to his back on ___. The ___ chiropractor reviewer also noted that on 8/16/02 the patient underwent lumbar fusion surgery. The ___ chiropractor reviewer further noted that postoperatively the patient was treated with physical therapy and rehabilitation. The ___ chiropractor reviewer explained that after 7 weeks of therapy, there is no documented subjective or objective improvement. The ___ chiropractor reviewer indicated that the treatment rendered to this patient was not relieving his pain or making him strong enough to return to his previous job. The ___ chiropractor reviewer explained that there is no significant benefit or correction that will be made by continuing to manipulate a fused spine. The ___ chiropractor reviewer also explained that some of the treatment rendered to this patient postoperatively could have been performed at home without supervision. Therefore, the ___ chiropractor consultant concluded that the hot/cold pack therapy, therapeutic exercises, massage therapy, therapeutic procedures, myofasical release, ultrasound, office visits (99212) and office visits (99212-52) from 1/17/03 through 8/8/03 were not medically necessary to treat this patient's condition.

Sincerely,